**THE INSURANCE CODE OF 1956 (EXCERPT)**
**Act 218 of 1956**

## 500.3501 Definitions.

Sec. 3501. As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or any other institution, organization, or person having a contract with a health maintenance organization to render 1 or more health maintenance services to an enrollee.

(b) "Basic health services" means:

(*i*) Physician services including consultant and referral services by a physician, but not including psychiatric services.

(*ii*) Ambulatory services.

(*iii*) Inpatient hospital services, other than those for the treatment of mental illness.

(*iv*) Emergency health services.

(*v*) Outpatient mental health services, not fewer than 20 visits per year.

(*vi*) Intermediate and outpatient care for substance abuse as follows:

(A) For group contracts, if the fees for a group contract would be increased by 3% or more because of the provision of services under this subparagraph, the group subscriber may decline the services. For individual contracts, if the total fees for all individual contracts would be increased by 3% or more because of the provision of the services required under this subparagraph in all of those contracts, the named subscriber of each contract may decline the services.

(B) Charges, terms, and conditions for the services required to be provided under this subparagraph shall not be less favorable than the maximum prescribed for any other comparable service.

(C) The services required to be provided under this subparagraph shall not be reduced by terms or conditions that apply to other services in a group or individual contract. This sub-subparagraph shall not be construed to prohibit contracts that provide for deductibles and copayment provisions for services for intermediate and outpatient care for substance abuse.

(D) The services required to be provided under this subparagraph shall, at a minimum, provide for up to $2,968.00 in services for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(E) As used in this subparagraph, "intermediate care", "outpatient care", and "substance abuse" have those meanings ascribed to them in section 3425.

(*vii*) Diagnostic laboratory and diagnostic and therapeutic radiological services.

(*viii*) Home health services.

(*ix*) Preventive health services.

(c) "Credentialing verification" means the process of obtaining and verifying information about a health professional and evaluating that health professional when that health professional applies to become a participating provider with a health maintenance organization.

(d) "Enrollee" means an individual who is entitled to receive health maintenance services under a health maintenance contract.

(e) "Health maintenance contract" means a contract between a health maintenance organization and a subscriber or group of subscribers, to provide, when medically indicated, designated health maintenance services, as described in and pursuant to the terms of the contract, including, at a minimum, basic health maintenance services. Health maintenance contract includes a prudent purchaser contract.

(f) "Health maintenance organization" means an entity that does the following:

(*i*) Delivers health maintenance services that are medically indicated to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.

(*ii*) Is responsible for the availability, accessibility, and quality of the health maintenance services provided.

(g) "Health maintenance services" means services provided to enrollees of a health maintenance organization under their health maintenance contract.

(h) "Health professional" means an individual licensed, certified, or authorized in accordance with state law to practice a health profession in his or her respective state.

(i) "Primary verification" means verification by the health maintenance organization of a health professional's credentials based upon evidence obtained from the issuing source of the credential.

(j) “Prudent purchaser contract” means a contract offered by a health maintenance organization to groups or to individuals under which enrollees who select to obtain health care services directly from the organization or through its affiliated providers receive a financial advantage or other advantage by selecting those providers.

(k) “Secondary verification” means verification by the health maintenance organization of a health professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential.

(*l*) “Service area” means a defined geographical area in which health maintenance services are generally available and readily accessible to enrollees and where health maintenance organizations may market their contracts.

(m) “Subscriber” means an individual who enters into a health maintenance contract, or on whose behalf a health maintenance contract is entered into, with a health maintenance organization that has received a certificate of authority under this chapter and to whom a health maintenance contract is issued.

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